Healthy Way LA
LOS ANGELES COUNTY

What is Healthy Way LA (HWLA)? HWLA is a no cost health care program operated by Los Angeles County. If you are approved for the program, you can get full health coverage. This includes doctor's visits at a primary care medical home (a clinic), prescription drugs, hospital services, and access to specialists.

Who Can Get Healthy Way LA? Adults who:

- Are between 19 to 64 years of age
- Live in Los Angeles County
- Are a United States Citizen/National or Legal Permanent Resident for at least five years or Qualified Immigrant
- Have monthly income at or below 133% of the Federal Poverty Level (FPL), or approximately $1,274 per month for a family of one
- Not pregnant and not eligible for Medi-Cal Programs

How Do I Sign Up?
It is easy to apply for this program. It can be done by mail. To the complete the process:

1. Complete and sign the HWLA APPLICATION form.
2. Mail it to the address below.
3. Be sure to include your proof of citizenship or legal permanent residency, income and proof of address.
4. Please send your information to:

HWLA Administration
P.O. Box 825
Atwood, CA 92811

For proof of your citizenship or legal permanent residency, please mail a **copy** of one of the items below:

- U.S. Birth Certificate
- U.S. Passport
- U.S. Certificate of Naturalization/Citizenship
- Legal Permanent Resident verification (Green Card)

For proof of your or your family's income, please mail a **copy** of one of the items below:

- Most recent paystub (from less than 45 days ago)
- Job statement from your employer that includes how much you are paid, how often and how many hours you work
- Last year's Federal Income Tax return (and "Schedule C" if self-employed)
- Award letter or copy of check from income source, such as:
  - Unemployment Insurance Benefits (UIB), Disability Insurance Benefits (DIB), or Veterans Benefits
- Letter from person providing you with free housing, utilities and/or food

For proof of your LA County address, please mail a **copy** of one of the items below:

- Valid California Driver's license
- California ID card from the Department of Motor Vehicles
- Recent letter addressed to you with cancelled U.S. Post Office stamp
- Most recent utility bill
- Most recent rent receipt or letter from person providing you with housing

If you have any questions about the enrollment process, call the Department of Public Social Services Customer Service Center at 1-866-613-3777.

HEALTHY WAY LA (HWLA) APPLICATION

Instructions

To apply for HWLA:

1. Please complete each section of this form. If you need more space, attach a separate sheet.
2. Be sure you sign and date the form.
3. Be sure to include the required documentation.
4. Use the envelope sent with this letter to send the form and documents.

If you have any questions, please call: DPSS Customer Service Center
1-866-613-3777

To learn more about HWLA, visit our website at http://dhs.lacounty.gov/HWLA.

Section 1: About You

Please use black or blue ink and print your answers below:

Last Name	First Name	Middle Name	Social Security Number

Current Street Address, Apartment Number	City/State	Zip Code
Mailing Address (if different from above)	**City/State**	**Zip Code**

(a) What is your gender? □ Male □ Female

(b) What is your marital status? (Please check one)

□ Never Married □ Married Date: _____

□ Divorced □ Common Law □ Separated □ Widowed

(c) What is your preferred language?

Spoken: _____ Written: _____

(d) What is your race or ethnicity?

□ Alaskan Native □ Asian Indian □ Amerasian □ American Indian □ African American □ Cambodian

□ Chinese □ Filipino □ Guamanian □ Hawaiian □ Hispanic □ Korean □ Japanese

□ Laotian □ Pacific Islander/Other □ Samoan □ Unknown □ Vietnamese □ White □ Other

Section 2: Family Size

(a) How many people are in your family? _____

Note: Be sure to include:

- *You*
- *Your spouse. If you are not married, include your partner if you have children in common.*
- *You children under age 21 who live with you and/or your children under age21 who don't live with you but who you are responsible for*
- *If you are a caretaker of your relative's children under age 21 (e.g., grandchildren, niece/nephew) who live in the home and whose parents are either absent or deceased*
- *If you are a child under age 21 in the home, include your parents and siblings.*

(b) Please complete the table below for each family member.

Name	**Relationship**	**Birthdate** (Month/Day/ Year)	**Birthplace** (Country)	**Employed** (Yes / No)	**Social Security #** (required if applying for aid)	**Applying for Aid?** Yes / No

(c) Is anyone pregnant in your family? □ Yes □ No

If yes, who?

_____

Section 3: Income

(a) Do you or any family member in the home get money from: □ Yes □ No

- A job
- Child support or alimony
- Social Security
- Interest or dividends
- Unemployment or Disability Benefits
- Veteran Benefits
- Retirement
- Gifts

If yes, complete the table below. List each source of income on a new line. Attach proof for each source of income.

Name of Person with Income	**Source of Income**	**Income Amount**	**How often Paid**	**How many hours worked**

(b) Does your household get all of the rent, utilities, or food for free? □ Yes □ No

If yes, complete the table below.

Item	Received Yes / No	Item is: Free / Earned	Name of person who provides this to you
Housing			
Utilities			
Food			

Section 4: Expenses and Deductions

Do you or any family member in the home pay for: □ Yes □ No

- Child or adult care
- Health insurance or Medicare premiums
- Court-ordered child support or alimony
- Educational expenses

If yes, complete the table below. List each type of payment you make on a new line. Attach proof of payment.

Name of Person with Expense/Deduction (include first and last name)	Type of Payment	Amount of Payment	Paid to Whom	How Often Paid *(weekly, monthly, twice a month)*

Section 5: Disability/Incapacity

Do you or any family member have a physical or emotional problem that makes it difficult to work, take care of personal needs, or take care of your children? □ Yes □ No

If yes, complete the section below.

Who? _____

Please explain: _____

Section 6: Citizenship / Immigration Status

Check the statement that describes you best:

I am/ the applicant is a: □ Citizen □ National □ Naturalized Citizen □ Other

□ Legal Permanent Resident A# _____ Entry Date: _____

Section 7: Insurance Coverage

Do you have any form of health insurance? □ Yes □ No

If yes, type of insurance

_____

Section 8: Health Status

In general, how would you rate your or the patient's health? (Circle one)

Excellent Very Good Good Poor Fair Don't know

Section 9: Medical Home

Please choose the name of the medical home clinic. This would be the clinic where you would see a doctor and receive primary care. If you do not choose a clinic, you will be assigned one that is the closest clinic to your home. A list of clinics you can choose from can be found on the HWLA website. Go to http://dhs.lacounty.gov/hwla. Look in the "HWLA Provider Directory" under the "For HWLA Members" section.

Name of the medical home clinic you choose: _____

Section 10: Signature and Certification

Person completing this form must read and sign below.

With this document, I apply for Healthy Way LA (HWLA) Program. Failure to provide the requested documents may result in the denial of the HWLA Program. Documents need to be received within 10 days of receipt of this application.

I declare under penalty of perjury under the laws of California that I/the HWLA enrolled am not covered by Medi-Cal. By my signature, I certify under penalty of perjury that the information I have provided is true and complete to the best of my knowledge and belief.

I authorize that the facts I provided may be checked with facts given by other institutions or government agencies, such as employers, banks, Social Security Administration, Franchise Tax Board, and the Department of Public Social Services (such as Cal-Fresh or General Relief), and the Income Eligibility Verification System (IEVS). These sources will be used to complete missing information in my application, such as income or family size, if possible. If this electronic information would cause the HWLA Program to deny my enrollment, I will have the chance to show that the electronic facts are wrong.

I certify that during the next year, if my family size or income changes, I promise to immediately report that fact to the facility where I am receiving services.

Signature		Date
Email Address:	Home Telephone Number:	Cellular Number:
Signature of Witness (**If signed by a mark** or an Interpreter or a Person Assisting)		